



**Department
of Health**

**Office of
Mental Health**

**Office of Alcoholism and
Substance Abuse Services**

**Office of Children
and Family Services**

Early Intervention Information

for

**Health Homes and Case Management
Agencies**

December 13, 2016



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Early Intervention Program

Agenda

Purpose of Today's Presentation:

- ✓ Overview of Early Intervention Program, Mission, and Services
- ✓ Early Intervention Steps
 - ✓ Referral to Early Intervention from Health Home (warm handoff between programs)
 - ✓ Referral to Health Home from Early Intervention (warm handoff between programs)

- ✓ Role and Responsibilities of Early Intervention Initial Service Coordinator
- ✓ Role and Responsibilities of Early Intervention Ongoing Service Coordinator



The Early Intervention Program

A statewide program that provides many different types of therapeutic and supportive services to infants and toddlers, birth to three years of age, with disabilities and their families.

Early Intervention Mission

To identify and evaluate as early as possible those infants and toddlers whose healthy development is compromised and to provide for appropriate intervention to improve child and family development.



Early Intervention Key Personnel

- ✓ Early Intervention Officials (EIO)
- ✓ Initial Service Coordinators (ISC)
- ✓ Ongoing Service Coordinators (OSC)
- ✓ Evaluators (Multidisciplinary Evaluation-MDE)
- ✓ Service Providers (Individuals and Agencies)



Children Served by the Early Intervention Program

Children must be:

- Under three years old
- **AND**
- Have a diagnosed condition that has a high probability of resulting in a developmental delay
- **OR**
- A developmental delay in one or more of the 5 areas of development



Types of Early Intervention Services

Applied Behavioral Analysis	Occupational Therapy	Respite Services
Assistive Technology Devices and Services	Physical Therapy	Transportation Services
Audiology Services	Psychological Services	Vision Services
Family Training, Counseling, Parent Support Groups	Service Coordination	Other Related Health Services that the child may need during service provision
Medical Services for Diagnostic/Evaluation Services	Special Instruction	
Nursing Services	Speech Language Pathology	
Nutrition Services	Social Work Services	

How Early Intervention Services are Provided

- Home and community-based visits
- Facility-based services
- Parent-child groups
- Family/caregiver/sibling support groups
- Group developmental intervention



Step 1: Referral

- Parents can make a referral for their own child to the Early Intervention Official (EIO)/Early Intervention Program in the county in which they live
- Primary Care Physician and certain other health care professionals must make referrals when there is a concern about a child's development, unless the parent objects
- EIO/ County EI Program receives referral
- EIO assigns Initial Service Coordinator (ISC)



Considerations for Making a Referral to Early Intervention Program Prior to Enrollment in Health Home

- Age of Child
 - Under the age of 3 years
- Potentially Eligible for Early Intervention
 - Does the child have a diagnosed condition with a high probability for developmental delay?
 - Is there suspicion that the child has a developmental delay?

Discussion with the Parent/Family Regarding Referral

- What is the Early Intervention Program
 - General explanation of Early Intervention services
- Eligibility for the Early Intervention Program
- How can the Early Intervention Program help their child and family
 - Benefits of Early Intervention
- Confirm that the parent/family does not object to the referral to Early Intervention in the county that the family resides



Referral to Early Intervention

- Health Home/Case Management Agencies can contact the Early Intervention Official/County Early Intervention Program or provide information to the parent/family so they can make the referral
 - Listing of all County Early Intervention Programs is located on Department of Health's website

http://www.health.ny.gov/community/infants_children/early_intervention/county_eip.htm

If HH/CMA is making the referral provide basic information-

Child's name, sex, race, ethnicity, birth date

Name and address and telephone number of the parents



Health Homes Direct Connection with Early Intervention

- ✓ Health Homes and Early Intervention Providers will be encouraged to have direct connection to discuss referrals to each other's programs
- ✓ The Early Intervention Official (EIO) will be able to have a direct connection with Health Homes to make a referral to a Health Home when the child is not eligible for Early Intervention or is transitioning from Early Intervention
- ✓ The Health Home will have a direct connection to the County EIO to discuss possible children that would be appropriate for Early Intervention prior to Health Home enrollment and to make a referral.**
- ✓ Communication between the Health Home and the EIO should continue to transition the child appropriately and ensure team alignment when establishing enrollment



Health Home *Chronic Condition* Eligibility Criteria

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to be enrolled in a Health Home **must** have:
 - **Two or more chronic conditions** (e.g., Substance Use Disorder, Asthma, Diabetes*) **OR**
 - One single qualifying chronic condition:
 - ✓ HIV/AIDS or
 - ✓ Serious Mental Illness (SMI) (Adults) or
 - ✓ Serious Emotional Disturbance (SED) or Complex Trauma (Children)
- Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home)
- In addition, the Medicaid member **must** be appropriate for the intensive level of care management services provided by Health Home, i.e., satisfy appropriateness criteria



Health Home Appropriateness Criteria

Individuals must meet the Chronic Condition Criteria AND be Appropriate for Health Home Care Management

Appropriateness Criteria: Individuals meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:

- ✓ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
- ✓ Has inadequate connectivity with healthcare system;
- ✓ Does not adhere to treatments or has difficulty managing medications;
- ✓ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- ✓ Has deficits in activities of daily living, learning or cognition issues, or
- ✓ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.



Crosswalk of Chronic Conditions Between Health Homes and Early Intervention

- Eligibility for Early Intervention includes diagnosed conditions and developmental delays
- There is a number of Chronic Conditions that meet both EI Eligibility and HH Chronic Condition Eligibility
- Identified ICD-10 Codes that crosswalk between both HH and EI



Conditions that Make a Child Eligible for the Early Intervention Program and on the Health Home Eligibility List

ICD-10 Code

ICD-10 Description

F43.10	Post-traumatic stress disorder, unspecified
F43.12	Post-traumatic stress disorder, chronic
P07.01	Extremely low birth weight newborn, less than 500 grams
P07.02	Extremely low birth weight newborn, 500-749 grams
P07.03	Extremely low birth weight newborn, 750-999 grams
Q05.0	Cervical spina bifida with hydrocephalus
Q05.1	Thoracic spina bifida with hydrocephalus
Q05.2	Lumbar spina bifida with hydrocephalus
Q05.3	Sacral spina bifida with hydrocephalus
Q05.4	Unspecified spina bifida with hydrocephalus
Q05.5	Cervical spina bifida without hydrocephalus
Q05.6	Thoracic spina bifida without hydrocephalus
Q05.7	Lumbar spina bifida without hydrocephalus
Q05.8	Sacral spina bifida without hydrocephalus
Q05.9	Spina bifida, unspecified
Q35.1	Cleft hard palate
Q35.3	Cleft soft palate
Q35.5	Cleft hard palate with cleft soft palate
Q35.7	Cleft uvula



Crosswalk Conditions (cont'd)

ICD-10 Code

Q35.9

Q36.0

Q36.1

Q36.9

Q37.0

Q37.1

Q37.2

Q37.3

Q37.4

Q37.5

Q37.8

Q37.9

ICD-10 Description

Cleft palate, unspecified

Cleft lip, bilateral

Cleft lip, median

Cleft lip, unilateral

Cleft hard palate with bilateral cleft lip

Cleft hard palate with unilateral cleft lip

Cleft soft palate with bilateral cleft lip

Cleft soft palate with unilateral cleft lip

Cleft hard and soft palate w/ bilateral cleft lip

Cleft hard and soft palate w/ unilateral cleft lip

Unspecified cleft palate w/ bilateral cleft lip

Unspecified cleft palate w/ unilateral cleft lip



Process for HH CMA who has a HH Referral and believes the child will be eligible for Early Intervention Prior to March 2017

- Confirm that Parent wants a referral to the Early Intervention Program
- Referral to Early Intervention occurs by HH CMA contact the County EIO
- EI Multidisciplinary Evaluation (determines EI eligibility)
- Individualized Family Service Plan Meeting
- Ongoing Service Coordinator Identified



Child Who Does Not Meet Eligibility for Early Intervention

- EI Multidisciplinary Evaluation (determines child not EI eligible)
- Communication back to the referring Health Home that child does not meet EI eligibility
 - Initial Service Coordinator, Early Intervention Official and HH Case Management Agency collaboratively work together (warm handoff back to Health Home)
- Health Home Steps and Procedures Continue



Step 2: Initial Service Coordinator

EIP regulations definition

As the service coordinator designated by the Early Intervention Official upon receipt of a referral of a child thought to be eligible for early intervention services who functions as the service coordinator who participates in the formulation of the Individualized Family Service Plan



Initial Service Coordinator Responsibilities

- Acts as the primary point of contact for the family from the time of the referral to the Initial IFSP meeting
- Explains the Early Intervention Program (EIP) and helps parents understand their due process rights
- Discusses the use of the family's private insurance and/or Medicaid and obtains all health insurance information
- Assists the family with applying for any health benefit programs for which they may be eligible
- Coordinates the planning of the Early Intervention evaluation and helps parents select an evaluator from an approved evaluator list
- Coordinates with medical and health care providers



Initial Service Coordinator Responsibilities (cont'd.)

- Helps to ensure that the federally-required timeline of 45 days between the child's referral to the EIP and the date of the initial Individualized Family Service Plan (IFSP) meeting is met
- In conjunction with the evaluator, notifies Office of People with Developmental Disabilities (OPWDD) if a child is thought to be potentially eligible for OPWDD services
- Attends and participates in the Initial IFSP meeting



Initial Service Coordination Responsibilities: Insurance Information

- Discuss with families the requirements for collecting their insurance information and that insurance can only be used when their plan/policy is “regulated” by New York State Insurance Law
- Explain the protections afforded to families under Insurance Law for regulated plans
- Inform families that they can provide written consent for their “non-regulated” insurance to be billed, and ensure they are aware of the potential risks
- Assist families in determining whether their insurance plan is regulated or non-regulated, if they are uncertain
- Complete all required third-party insurance forms and paperwork
- Confirm/update all third party insurance information with the family on a frequent basis
- Ensure that the child’s service providers receive the most current insurance information



Payment- Initial Service Coordination

- Initial Service Coordination is paid through the Early Intervention Program
EI Fee for Service Rate

Step 3: Multidisciplinary Evaluation

A Multidisciplinary Evaluation determines eligibility for Early Intervention. It includes:

- Use of appropriate standardized evaluation and assessment instruments by two or more qualified professionals to assess the 5 developmental domains: physical, cognitive, communication, social-emotional, and adaptive
- Assessment of the child's health status (e.g., vision and hearing screening, and neurological assessment), and review of health records
- Use of Informed Clinical Opinion and Direct Observation
- Parent Interview
- Family Assessment (optional for family)
- Review of other pertinent source of information about the child, with parental consent



Initial Eligibility Criteria Based on Developmental Delay

12-month or 33 percent delay, or a score of at least 2 standard deviations (SDs) below the mean in one functional area

OR

25 percent delay or a score of 1.5 SDs below the mean in at least two functional areas



Eligibility Criteria Based on Communication Delay Only

For children found to have a delay in only the communication domain, delay is defined as:

- Score of 2 SDs below the mean in the entire communication domain;

OR

- If no standardized test is available or appropriate for the child, or the tests are inadequate to accurately represent the child's development in the informed clinical opinion of the evaluator, a delay in communication shall be a severe or marked regression in communication development



Initial Service Coordinator Responsibilities After the Evaluation

Child Found Not Eligible

- Review due process rights with the parents and assist them in accessing these rights if they disagree with the eligibility determination
- **Assist the family with referrals to other recommended community programs and resources (HH referral possible)**
- Ensure the family has received information about developmental milestones from the evaluator, and are aware that the child can be re-referred to the EIP at a future time if concerns persist or new concerns emerge
- Ensure the family is aware of the Child Find Program (screening and tracking), if appropriate



Step 4: Initial Individual Family Service Plan (IFSP) Meeting

When a child is found eligible through an MDE, an IFSP meeting is convened by the EIO.

- The ISC, evaluator, EIO/D, and parents are required to attend
- The parents play an important role at this meeting and help to identify the outcomes and objectives they want their child and family to accomplish
- The family chooses an Ongoing Service Coordinator (OSC)
- EI services (including frequency, intensity, duration) are determined and a service plan (IFSP) is written
- All members of the IFSP team, including the EIO and the Parent, agree to the services outlined in the IFSP
- EIO and parent sign the IFSP and the OSC begins to initiate services
- In conjunction with the evaluator, the ISC notifies the Office of People with Developmental Disabilities if the child is thought to be potentially eligible for OPWDD services



Initial Service Coordinator (ISC) Responsibilities

The ISC is a member of the Initial Individualized Family Service Plan (IFSP) Team. They are required to:

- Attend the IFSP meeting and participate in the development of the child's first service plan
- Facilitate communication between the family and evaluator, and ensure that the parents' concerns, priorities, and resources have been addressed by the evaluation team
- Ensure that a statement of other services not required or funded by the EIP but needed by the child and family, including medical services, is included in the IFSP, and the steps the service coordinator will take to secure or help the family secure these services



Initial Service Coordinator Responsibilities (cont'd.)

- Ensure that the IFSP contains a statement of measurable results/outcomes expected to be achieved for pre-literacy and language skills, as developmentally appropriate for the child
- Ensure that parents are provided with the opportunity to select an Ongoing Service Coordinator (OSC)
- Ensure that the parents receive a copy of the IFSP



Ongoing Service Coordinator

EIP regulations definition

The service coordinator designated in the individualized family service plan

Step 4: Implementing EIP Services

Once the Ongoing Service Coordinator (OSC) is chosen by the parent at the Initial Individualized Family Service plan (IFSP) Meeting, the OSC:

- Implements the IFSP by identifying appropriate EI service providers based on the individual needs of the child and family, and makes referrals to EI providers for needed EI services identified in the IFSP
- Coordinates the provision of all EI and other services (educational, social, and medical for other than diagnostic and evaluation purposes that the child and family need
- Ensures that the entire IFSP and all services are implemented within 30 calendar days of the projected date for the initiation of services in the IFSP
- The projected date for the initiation of services is as soon as possible but no later than 30 days after the parent provides written consent for the services in the IFSP or any subsequent amendments to the IFSP
- When services do not begin within the 30-day timeline, the OSC must document the reasons for the delay in the EI data system (NYEIS) and in the child's record



Ongoing Service Coordinator (OSC) Responsibilities

Immediately upon being chosen by the parent, the OSC must:

- Consult with the Initial Service Coordinator (ISC) to identify family issues or needs that could impact provider assignment, such as demographics, language and communication, scheduling needs, and other unique family issues
- Review the IFSP developed at the Initial IFSP meeting to understand the child's and family's service needs, including the services types and frequencies, and whether any specialties are needed
- Contact the family
- Make referrals to providers for needed EI services and other services identified in the IFSP, and schedule appointments for children and families



Ongoing Service Coordinator (OSC) Responsibilities (cont'd)

- Coordinate the provision of EI services and other services that the child and family need (educational, social, and medical services for other than diagnostic and evaluation purposes)
- Attend all IFSP reviews and participate in team discussions to identify and incorporate the family's concerns, priorities, and resources into the IFSP
- Maintain documentation of all service coordination activities in the child's record, including circumstances that impact timeliness
- Maintain confidentiality of child records (including sensitive information) and of personally identifiable information
- Coordinate, facilitate, and monitor the delivery of services to ensure they are being delivered in a timely manner in accordance with the IFSP through home visits, telephone contacts, and meetings with the parent and service providers to foster collaboration and integration of service strategies



Ongoing Service Coordinator (OSC) Responsibilities (cont'd)

- Coordinate the performance of any additional evaluations and assessments
- Consult with evaluator when a child is thought to be potentially eligible for OPWDD services
- When child is in foster care, keep the Local Department of Social Services' caseworker informed of the child's progress
- Assist families moving to another municipality with the transfer of all appropriate case records, with parental consent
- Assist families moving to another state with a referral to the EIP and with the transmittal of appropriate case records, with parental consent
- Develop the transition plan to preschool or other appropriate supports and services and complete the required transition steps and services



Step 5: IFSP Reviews and Annual Evaluation

As a member of the Individualized Family Service Plan (IFSP) team, the Ongoing Service Coordinator (OSC):

- Attends the 6-month reviews and annual evaluations of the IFSP; or at more frequent intervals at the request of the parent or if conditions warrant
- Ensures that each IFSP accurately reflects the child's and family's needs.
- Implements changes to the IFSP that are agreed upon by the IFSP team



Step 6: Transition

- Transition is the process of preparing children and families to leave the EIP
- Ongoing Service Coordinator (OSC) begins discussing transition and all associated activities with the family at the IFSP meeting closest to the child's second birthday to ensure all required timelines are met
- The service coordinator, in collaboration with the family and IFSP team, develops a Transition Plan for ALL children exiting the EIP, including those found eligible for Committee on Preschool Special Education (CPSE) services, those who are not thought to be eligible for CPSE but may require other services in the community after EI, and those who leave the EIP and do not require additional services



Developing the Transition Plan

The Ongoing Service Coordinator (OSC) is responsible for developing the transition plan, which includes:

- all required transition steps for the child and family to exit the EIP
- actions to help the child adjust to a new setting
- actions to prepare the family
- procedures to prepare new program staff or individual qualified personnel who will be working with the child and family



Transition of Children Who May Meet HH Eligibility

- For children the Ongoing Service Coordinator believes meets Health Home eligibility and appropriate (Chronic Conditions and Appropriateness)
- The OSC will discussion with parent/family regarding what is Health Home and that the child may be eligible and appropriate
- The OSC will obtain verbal consent to make a referral for the Health Home Program
- Ongoing Service Coordinator will make a referral (warm handover) by contacting the Health Homes



OSC Responsibilities – Child Thought to be Potentially Eligible for CPSE

Transition to community services:

- Assist the parent in identifying, locating and accessing other early childhood and supportive services that may be needed by the child and family. This includes a referral to:
 - Early Childhood Direction Center
 - Child Care Resource and Referral Program
 - Other appropriate resources
- With parental consent, convene a conference with the EIO, parents, and providers of other appropriate community services that the child may need or benefit from to discuss the appropriateness of these services
- EIP services end on the day before the child's third birthday



Common Responsibilities of ISC and OSC

- Assist the parent of an eligible child in gaining access to early intervention and other services identified in the IFSP
- Ensure the IFSP outcomes and strategies reflect the family's concerns, priorities, and resources; and that changes are made as the family's/child's needs change
- Coordinate the provision of all services that the child and family need or are receiving
- Facilitate the timely delivery of services
- Continuously seek appropriate services and situations that benefit the development of the eligible child for the duration of the child's eligibility



Common Responsibilities of ISC and OSC (cont'd)

- Maintain regular, consistent contact with families, as the needs of the family dictate
- Contact can include home visits, phone contacts, and other meetings with the parent or service providers to foster collaboration and integration of service strategies
- Provide information to and assist families with complaint procedures as described in EIP regulations 69-4.17
- Maintain documentation of all activities (both billable and non-billable) in the child's record
- Use of NYEIS (EI data system) to enter and routinely update family insurance/Medicaid information, assign service providers, complete transition activities, etc.



Processes for Communication between Health Homes and Early Intervention after March 2017

- Requiring that Health Homes and Early Intervention providers will be in communication with one another
- Warm-hand off processes need to be developed
- Health Homes need to have Early Intervention providers in their network
- Review of case scenarios are needed to determine implementation

See previous webinar:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/11_16_2016_ei_presentation_to_hh.pdf



Questions and Discussion



Updates, Resources, Training Schedule and Questions

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569
- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm



Early Intervention and Health Homes List of Acronyms

CPSE: Committee on Preschool Special Education (Section 4410: State Education Law section pertaining to 3 – 5 year olds)

EIO: Early Intervention Official

IFSP: Individualized Family Service Plan

ISC: Initial Service Coordinator

LDSS: Local Department of Social Services

MAP: Medicaid Analytics Performance Portal

MDE: Multidisciplinary Evaluation

MOU: Memorandum of Understanding

NYEIS: New York Early Intervention System (Data System)

OSC: Ongoing Service Coordination

